

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2020

01518

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

## 1. PLACE OF DEATH:

County CALVERT

City or town PRINCE FREDERICK, MD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

MRS ANNIE IRENE BOWEN

4. Sex

F.

5. Color or race

W

6. (a) Single, married, widowed, or divorced

widow

6. (b) Name of husband or wife

EZEKIEL BOWEN

7. Birth date of deceased (mo., day, yr.)

Sept 1887

6. (c) If alive, give age years

8. AGE:

58

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

BALTIMORE MD.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Ranphillion

12. Name

MOTHER FATHER ANNIE KELTON

13. Birthplace - BALTIMORE, MD

14. Maiden name

ANNIE KELTON

15. Birthplace -

16. Informant

Thomas Kelton Scrivener

Address

PRINCE FREDERICK, MD

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 2-12-45  
(month) (day) (year)

Cemetery or crematory

All Saints

Location

Huntingtown, MD

18. Funeral director

W.H. Hutchins

Address

Avenue, MD

19. Date rec'd by registrar

2-10-1945

J. H. King

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County CALVERT

City or town PRINCE FREDERICK

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 10 1945 at 3a m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 9 1945 to Feb 10 1945

and that I last saw her alive on Feb 9 1945

Immediate cause of death

General hemoptysis

Due to

Due to Hypertension c.v.d.

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

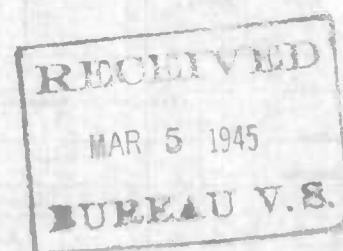
Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15

## CERTIFICATE OF DEATH

01519

Reg. Dist. No.

52

1. PLACE OF DEATH: Calvert

County.

City or town.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Joseph Coates

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MC3

6. (b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years      Months      Days      If less than one day  
                  17

5. (c) If alive, give age years

9. Birthplace

(Town, county, and state)

10. Usual occupation.

## 11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Feb. 14, 1943

(Date rec'd by registrar)

St EdmundsCalvert Co. Md.Robert RobertsonParis Md.John H. Hardesty

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

2/14 1943 at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 28 1943 to Feb 14 1943  
and that I last saw him alive on Feb 7 1943

Immediate cause of death

Pneumonia 7 days.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED

APR 5 1945

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *13C*

01520.

## CERTIFICATE OF DEATH

Reg. Dist. No. *51*

## 1. PLACE OF DEATH:

County *Calvert*  
City or town *Burtonsville*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

*(Addie.)*

## 3. (a) FULL NAME

*Mrs. Benjamin Coderman*

## 3. (b) Social Security Number

## 4. Sex

*F*

## 5. Color or race

*W*

## 6. (a) Single, married, widowed, or divorced

*W*

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

*Feb 17, 1922*

## 6. (c) If alive, give age years

## 8. AGE:

*23*

Years

Months

Days

If less than one day

hrs.

min.

## 9. Birthplace

*Calvert Co. Md*

(Town, county, and state)

## 10. Usual occupation

*Housewife*

## 11. Industry or business

## MOTHER FATHER

*Office Supplies*

## 12. Name

*Afriert C. and*

## 13. Birthplace

*Afriert Co. Md*

## 14. Maiden name

*Minnie Walter*

## 15. Birthplace

*Calvert Co. Md*

## 16. Informant

*Benz M. Coderman*

## Address

*Addie**Md*

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof *2-20-44*

(month) (day) (year)

## Cemetery or crematory

*St Pauls*

## Location

*Prince Frederick Md*

## 18. Funeral director

*W. H. Nutchins*

## Address

*Owings Md*

## 19. Date rec'd by registrar

*2-19 1944*

(Date rec'd by registrar)

*J. N. King*

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State *Md* County *Calvert*City or town *Burtonsville* (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

## 2. (a) If veteran, name war

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

*2/17/45*

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Jan 24 1945* to *Feb 17 1945*and that I last saw her alive on *Feb 17 1945*

## Immediate cause of death

*Influenza fat.*

## DURATION

*2 yrs*

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

## Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

M. D. or other

Address

*H. Harvey*

Date signed

RECEIVED

MAR 5 1945

BUREAU V.S.

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 512

01521

## CERTIFICATE OF DEATH

Reg. Dist. No. 50

## 1. PLACE OF DEATH:

County Cabret

City or town Lowell

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, Institution, or street address where death occurred:

Home

How long in hospital or institution?

## 3. (a) FULL NAME

Wilson Lowell

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife

Sadie Barnes Lowell

6. (c) If alive, give age 56 years

7. Birth date of deceased (mo. day, yr.)

May 22, 1875

8. AGE:

Years 69

Months 9

Days 5

If less than one day hrs. min.

B. Birthplace

Cabret Co. Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

Merchant

MOTHER FATHER

John Lowell

13. Birthplace

Md

14. Maiden name

Sarah Isabelle Gray

15. Birthplace

Md

16. Informant

Charles Lowell

Address

Lowell, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof March 1, 1945  
(month) (day) (year)

Cemetery or crematory

St Paul's

Location

Dushy, Md

18. Funeral director

O J. Nashman &amp; Son

Address

Mutual, Md

19. Date rec'd by registrar

1945

Dr. G. S. Coster

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County Cabret

City or town Lowell

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

No

## 3. (b) Social Security Number

220

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 27 1945 at 10:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 12 1944 to Feb 26 1945, and that I last saw him alive on Feb 26 1945.

Immediate cause of death

Acute Pulmonary Tuberculosis

DURATION

Due to

Due to

Other conditions Cerebrovascular Disease

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

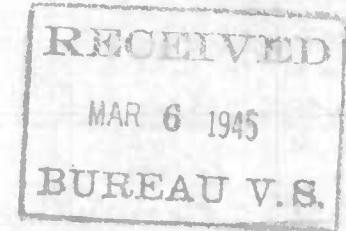
Means of injury

Injured at work

23. SIGNATURE

M. D. or other

Address Date signed



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2

01522

## CERTIFICATE OF DEATH

Reg. Dist. No. 52

## 1. PLACE OF DEATH:

County Calvert

City or town N. Beach MD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Annie Dayton Saffrey

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W

8. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

July 31, 1867

8. AGE:

Years

Months

Days

It less than one day

77

6

4

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

Henry C. Dayton

12. Name

FATHER

John

Catharine Colborn

13. Birthplace

Mother

N. Beach MD

Catharine Colborn

14. Maiden name

15. Birthplace

N. Beach MD

Catharine Colborn

Catharine Colborn

Catharine Colborn

Catharine Colborn

16. Informant

N. Beach MD

Catharine Colborn

Catharine Colborn

17. Burial

Burial

Cemetery or crematory

Location

Funeral director

Address

Feb. 5-1945

Date rec'd by registrar

Feb. 5-1945

Date signed

Annie Dayton Saffrey

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County Calvert

City or town N. Beach

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 4

1945, at 310A M

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 25 1945 to Feb 4 1945

and that I last saw her alive on Feb 3 1945

Immediate cause of death

Cardiac hemorrhage

Due to Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

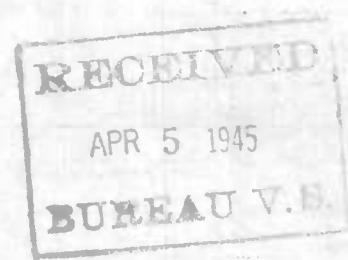
Annie Dayton Saffrey

M. D. or other

Address

Owings MD

Date signed



M

MARGIN RESERVED FOR BINDING

1

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

61523

## CERTIFICATE OF DEATH

Reg. Dist. No. 61

## 1. PLACE OF DEATH:

County

Calvert

City or town Island Creek, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

T. Wilson Hall

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife

Lucy S. Hall

6. (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.)

April 23, 1884

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Calvert Co., Md

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name

Thomas C. Hall

13. Birthplace

Calvert Co., Md

MOTHER

14. Maiden name

Rebecca W. Hutchins

15. Birthplace

Calvert Co., Md

16. Informant

Mr. Lucy S. Hall

Address

Island Creek, Md

17. Burial

Date thereof Feb 24, 1945

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Christ Church

Location

Port Republic, Md

18. Funeral director

G. A. Harkness &amp; Son

Address

Mutual, Md

19. Date rec'd by registrar

19 45

J. N. King

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Calvert

City or town

Island Creek

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

WW

## 3. (b) Social Security Number

720

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21, 1945 2 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19. . . . . to . . . . . 19. . . . .

and that I last saw him alive on . . . . . 19. . . . .

Immediate cause of death

Cardiac Declusion

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of . . . . .

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

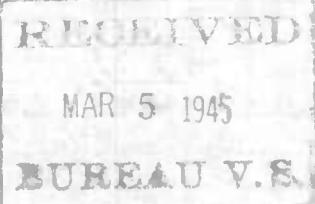
Means of injury

Injured at work?

23. SIGNATURE

George Hall M. D. or other

Smith Murdoch Date signed 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1460

01524

## CERTIFICATE OF DEATH

Reg. Dist. No. 5

## 1. PLACE OF DEATH:

County

CALVERT

City or town

PORT REPUBLIC MD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

HOUSE

How long in hospital or institution?

## 3. (a) FULL NAME

MARTINA BOOTS

4. Sex

F.

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Married (?)

8. (b) Name of husband or wife

THOMAS HARROD

7. Birth date of deceased (mo., day, yr.)

1905

8. (c) If alive, give age years

8. AGE:

39

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

PLUM POINT MD.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

George Boots

MOTHER

13. Birthplace

PARKERS GROVE, CALVERT COUNTY

14. Maiden name

Maggie Comodore

15. Birthplace

-

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

## (For newborn infants give residence of mother)

State

MARYLAND

County

CALVERT

City or town

PORT REPUBLIC

(If outside city or town limits, write RURAL and give nearest town)

Street No.

-

(If rural, give LOCATION)

2.(a) If veteran, name war

HARROD

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

FEBRUARY 5 1945

19.

at 10<sup>30</sup> P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

19.

and that I last saw h. alive on

19.

Immediate cause of death

Tonsillitis. Hernia  
with infection

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

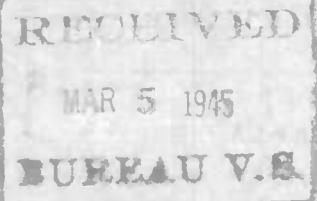
23. SIGNATURE

M. D. or other

Registrar

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1572

01525

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH: Calvert.  
County.....

City or town..... Huntingtown and  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME  
Clara Hurley.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
<u>F</u>	<u>C.</u>	

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) 8 - 17 - 1944.  
..... 8.(c) If alive, give age..... years

8. AGE: Years	Months	Days	If less than one day
<u>5</u>		<u>25</u>	hrs. ..... min.

9. Birthplace..... Huntingtown and  
(Town, county, and state)

10. Usual occupation.....

11. Industry or business

MOTHER FATHER	12. Name..... <u>Teresa Hurley</u>
	13. Birthplace..... <u>md</u>

MOTHER	14. Maiden name..... <u>Pauline Brown</u>
	15. Birthplace..... <u>Newtown MD.</u>

MOTHER	16. Informant..... <u>Pauline Hurley</u>
	Address..... <u>St Edmonds.</u>

17. Burial (Burial, cremation, or removal. Which?)	Date thereof..... <u>8 - 12 - 45</u> (month) (day) (year)
---	--

Cemetery or crematory..... <u>St Edmonds.</u>	
---	--

Location..... <u>Calvert, md</u>	
----------------------------------	--

18. Funeral director..... <u>P.E. Sawell</u>	
--	--

Address..... <u>Prince Frederick</u>	
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19. Date rec'd by registrar..... <u>2-12-45</u>	<u>18-45</u>
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Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... MD County..... Calvert

City or town..... Huntingtown, md  
(If outside city or town limits, write RURAL and give nearest town)

Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 8 - 11 - 1945 at 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... t9. to ..... t9.

and that I last saw h..... alive on ..... t9.

Immediate cause of death.....

Infantile Congenital Heart  
defect with  
terminal pneumonia

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? .....

(City or town) ..... (County) ..... (State) .....

Injured at home, farm, industry, public place (where?) .....

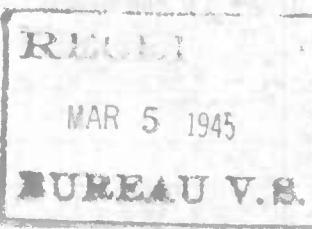
Means of injury.....

Injured at work? .....

23. SIGNATURE..... Page J. St

M. D. or other

Address..... Parrot Gulch Date signed..... 2/17/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

01526

## CERTIFICATE OF DEATH

Reg. Dist. No. 50

## 1. PLACE OF DEATH:

County.....

Calvert

City or town.....

Dawells, md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

half time

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

maggie E Johnson

4. Sex

F

5. Color or race

C.

6.(a) Single, married, widowed, or divorced

widow.

6.(b) Name of husband or wife.....

T.

6.(c) If alive, give age..... 62 years

7. Birth date of deceased (mo., day, yr.)

62

Years      Months      Days      If less than one day

....hrs. ....min.

9. Birthplace.....

Calvert, md

(Town, county, and state)

10. Usual occupation.....

Homemaker.

11. Industry or business

MOTHER FATHER

12. Name..... Thomas Rice

13. Birthplace.....

md.

14. Maiden name.....

T.

15. Birthplace.....

\_\_\_\_\_

16. Informant.....

Bertha Johnson.

Address.....

Dawells, md

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof..... 2-16-45

(month) (day) (year)

Cemetery or crematory.....

St Johns.

Location.....

Calvert.

18. Funeral director.....

P.E. Jewell

Address.....

Pr. Fred, md.

19. Date rec'd by registrar.....

Feb 16. 1945 - A.J. Brooks

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

md

County.....

Calvert-

City or town.....

Dawells, md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

2-15 1945 at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-29 1945 to 2-14 1945

and that I last saw her alive on 26-14-1945

19.

Immediate cause of death.....

Lobar pneumonia

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

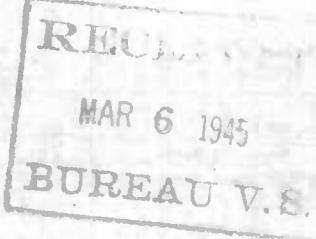
23. SIGNATURE.....

M. D. or other

Address.....

Prince Frederick 2-15-45

Date signed.....



M

MARGIN RESERVED FOR BINDING

1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

01527

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

## 1. PLACE OF DEATH:

County.....

Culvert -

City or town.....

Sunderland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Safe

Hospital, institution, or street address where death occurred:

Culvert -

How long in hospital or institution?.....

## 3. (a) FULL NAME

Edgar Wilson Jones.

4. Sex

m

5. Color or race

C.

6.(a) Single, married, widowed, or divorced

S.

6.(b) Name of husband or wife.....

8.(c) If alive, give age.....

years

7. Birth date of deceased (mo., day, yr.)

2-19-1926

8. AGE:

Years

Months

Days

If less than one day

19

hrs.

min.

9. Birthplace.....

Culvert Co.,

(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business

MOTHER FATHER

12. Name.....

Lucie Jones.

13. Birthplace

Md

14. Maiden name

Edna Jacks

15. Birthplace

Md

16. Informant.....

Lucie Jones.

Address

Sunderland, Md.

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof..... 2-21-45  
(month) (day) (year)

Cemetery or crematory.....

Palux ent.

Location.....

Culvert,

18. Funeral director.....

P. E. Sewell

Address

P. O. Box, Md.

19. (Date rec'd by registrar)

2-21-45

(Date rec'd by registrar)

J. M. King

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Culvert -

City or town.....

Sunderland .

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

2-19-1945 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw h..... alive on

19.....

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

Date signed.....

2-21-45

RECEIVED

MAR 5 1945

BUREAU V.S.

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH  
 of deceased & adding of date of death is shown on  
 FILM NO. G 94 APR 13 1945

2411 N. Charles St., Baltimore 13

11528

Reg. Date. No. 51

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:  
 County Calvert -  
 City or town Prince Frederick  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME William Joseph King

4. Sex m. 5. Color or race Colow

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) August 27, 1865

8. AGE: Years 79 Months 63 Days      It less than one day hrs.      min.

9. Birthplace Calvert  
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

MOTHER FATHER 12. Name Prince King

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant Arthur King

Address Prince Frederick, Md.

17. Burial Date thereof 2-25-45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Carroll

Location Calvert

18. Funeral director P. E. Sewell

Address Prince Frederick, Md.

19. Date rec'd by registrar Feb 25 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State Maryland County Calvert  
 City or town Bridgeton Frederick  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24, 1945, at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 21, 1945, to Feb 24, 1945,

and that I last saw him alive on Feb 21, 1945.

Immediate cause of death

Chronic nephritis

Due to Generalized arterio-

C. chronic arterio-

Due to Seminal

Other conditions Digital hemia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

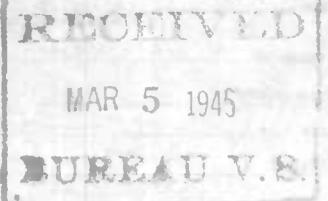
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURES

M. D. or other

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1702

01529

## CERTIFICATE OF DEATH

Reg. Dist. No. 57

## 1. PLACE OF DEATH:

County

Calvert  
Brentwood

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

M

5. Color or race

C

6. (a) Single, married, widowed, or divorced

W

## 8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years  
66

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

MOTHER

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Calvert

City or town

Brentwood

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 16

18 45 at 1025A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.

to

and that I last saw h. alive on

19.

Immediate cause of death

and sudden fracture of skull  
and killed rapidly

DURATION

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Incident Date of 2/16/45

Where did injury occur?

Brentwood Calvert Co. Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Road

Means of injury

Auto.

Injured at work? Yes

23. SIGNATURE

H. Ward M.D. or other

Address: Calvert Date signed: 2/17/45





RECEIVED  
APR 5 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-2

01531

## CERTIFICATE OF DEATH

Reg. Dist. No. 52

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed or divorced

MA

C

Widow

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb 14, 1883

8. AGE:

Years  
62Months  
18Days  
16If less than one day  
hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof  
(month) (day) (year)  
March 3, 1945

Cemetery or columbarium

St Edmunds

Location

18. Funeral director

Pembury Sewell

Address

Prince Frederick

19. Date rec'd by registrar

March 2, 1945 - Tom H. Hendesty

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

2/28 1985 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him alive on

19...

Immediate cause of death

Cerebral hemorrhage 2 days

Due to Found dead

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Edward J. and Margaret M. D. or other

Address Dr. Edward J. and Margaret M. D. or other Date signed

